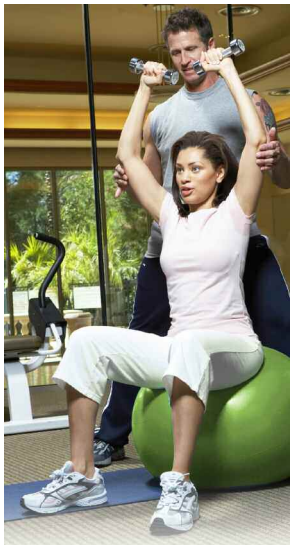
State of Illinois
Department of Central Management Services
Bureau of Benefits







Benefit Choice Options

Enrollment Period May 1 – June 15, 2012 | Effective July 1, 2012

Teachers' Retirement Insurance Program

Plan Administrators

Who to contact for information

Managed Care Plan Administrators	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Coventry Health Care HMO (formerly PersonalCare HMO)	(800) 431-1211	(217) 366-5551	chcillinois.coventryhealthcare.com
Coventry Health Care OAP (formerly PersonalCare OAP)	(800) 431-1211	(217) 366-5551	chcillinois.coventryhealthcare.com
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Health Plans and Medicare COB Unit	**CMS Group Insurance Division** 801 South 7th Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov
General Eligibility and Enrollment Information	**Teachers' Retirement System (TRS)** 2815 West Washington P.O. Box 19253 Springfield, IL 62794-9253	(800) 877-7896 (217) 753-0329 (TDD/TTY)	trs.illinois.gov

Plan administrator information continued on inside back cover.

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Message to Benefit Recipients

The Benefit Choice Period will be **May 1 through June 15, 2012**, for all benefit recipients. **Elections will be effective July 1, 2012**. Benefit recipients or dependent beneficiaries who have never been enrolled in TRIP may enroll during the Benefit Choice Period. The Benefit Choice Period is the **only** time of the year a benefit recipient may change health plans, with the following two exceptions: the benefit recipient's permanent address changes affecting availability to their HMO plan or the primary care physician leaves the benefit recipient's HMO plan.

All Benefit Choice changes should be made on the Benefit Choice form. Benefit recipients should complete the form **only** if changes are being made. Dependent beneficiaries must be enrolled in the same plan as the benefit recipient. If you are already enrolled in TRIP and wish to make a change in coverage, please call TRS for a new Benefit Choice form at (800) 877-7896 or visit the TRS website at **trs.illinois.gov**. The Benefit Choice form will only be sent upon request. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact TRS for a TRIP enrollment application.

During the Benefit Choice Period, benefit recipients may:

- Change health plans.
- Add dependent coverage if never previously enrolled (adding dependent coverage requires documentation).

Benefit Choice Changes for Plan Year 2013

(Enrollment Period May 1 – June 15, 2012)

The information below represents changes to the TRIP benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes. **The Benefit Choice Period will be May 1 through June 15, 2012.** All elections will be effective July 1, 2012.

- **Managed Care Contracts** In an effort to ensure that health carriers are in place for the start of the next fiscal year (July 1, 2012), a decision has been made to enter into emergency contracts with Health Alliance HMO, Health Alliance Illinois and Coventry Health Care HMO. These contracts will be for 90 days with an option to extend for an additional period as needed. During the FY 2013 Benefit Choice Period, members may choose from the following carriers: HealthLink OAP, Coventry Health Care OAP, HMO Illinois, BlueAdvantage HMO, Health Alliance HMO, Health Alliance Illinois, Coventry Health Care HMO or the Teachers' Choice Health Plan.
- **HMO Illinois and BlueAdvantage HMO Medical Group Code** Benefit recipients and/or dependents enrolling in HMO Illinois or BlueAdvantage HMO must enter a 3-digit medical group code on the Benefit Choice Election Form. Medical group codes can be found on the provider directory page of the plan administrator's website. Benefit recipients may call HMO Illinois or BlueAdvantage HMO for assistance.
- **Federal Healthcare Reform** Effective July 1, 2012, the copayment for compound drugs will be at the nonpreferred drug level due to compound drug billing layout changes as a result of federal healthcare reform. Patients who are prescribed compound drugs are encouraged to contact their doctor for less expensive alternatives. Please note, a compound drug is one which requires a prescription from a doctor and is prepared by a pharmacist, who mixes or adjusts drug ingredients to customize a medication to meet a patient's individual needs.

Benefit Recipient Responsibilities

It is each benefit recipient's responsibility to know plan benefits and make an informed decision regarding coverage elections. Notify the Teachers' Retirement System (TRS) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
  - birth/adoption of a child;
  - marriage, divorce, legal separation, annulment;
  - death of spouse or dependent;
  - dependent(s) loss of eligibility;
  - a court order results in the gain or loss of a dependent;
  - a change in Public Aid recipient status;
  - dependent becomes covered by other group health coverage.
- Change in Medicare status
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their coordination of benefits (COB) information to TRS as soon as possible.

Important Reminders

Transition of Care after Health Plan Change: Benefit recipients and their dependents who elect to change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Benefit recipients or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

Terminating TRIP Coverage: To terminate coverage at any time, notify TRS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit recipients and dependent beneficiaries who terminate from TRIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

Notification of Other Group Coverage: It is the benefit recipient's responsibility to notify TRS of any addition of, or change to, other group insurance coverage during the plan year. The participant must provide their coordination of benefits (COB) information to TRS as soon as possible.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other benefit recipients.

Documentation Requirements: Documentation, including the SSN, is required when adding dependent coverage.

Coverage and Monthly Premiums

Benefit recipients who enroll in the Teachers' Retirement Insurance Program (TRIP) receive health, prescription and behavioral health coverage. Dependent beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the benefit recipient. The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

As a benefit recipient enrolled in TRIP, you are offered various health insurance coverage options:

✦ **Teachers' Choice Health Plan (TCHP)**

✦ **Managed Care Plans** (two types)

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide and the doctors and hospitals you can access. See the Benefits Comparison charts on pages 8-13 for information to help you determine which plan is right for you.

If you change health plans during the Benefit Choice Period, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. If you need to have services but have not yet received your ID cards, contact your health insurance carrier.

Remember, whatever health plan you elect during the Benefit Choice Period will remain in effect the entire plan year unless you experience a qualifying change in status that allows you to change plans.

Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
	Under Age 26	Age 26-64	Age 65 and Above	All Ages
Benefit Recipient enrolled in any managed care plan	$62.25	$193.34	$263.41	$76.41
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	$161.54	$455.92	$685.68	$198.93
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	$80.77	$227.97	$342.85	$99.47
Dependent Beneficiary enrolled in any managed care plan	$249.06	$773.33	$1,053.62	$264.69**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	$323.07	$911.83	$1,371.34	$397.88
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	$323.07	$911.83	$1,371.34	$298.41**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See inside front cover for contact information.

** Medicare Primary Dependent Beneficiaries enrolled in a managed care plan, or in TCHP when no managed care plan is available, receive a premium subsidy.

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Managed care plans have limitations including geographic availability and defined provider networks, whereas the Teachers' Choice Health Plan has a nationwide network of providers available to its benefit recipients.

Teachers' Choice Health Plan (TCHP)

TCHP is the medical plan that offers a comprehensive range of benefits. Under the TCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a TCHP network provider.

The TCHP has a nationwide network that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the TCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction.

TCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits. Plan participants can access plan benefit and participating TCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Benefit recipients must select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment applies. No annual plan deductibles apply for medical services through an HMO. The minimum level of HMO coverage provided by all plans is described on the charts on pages 8-13. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

  If a benefit recipient is enrolled in an HMO and their PCP leaves the HMO plan's network, the benefit recipient has three options:

  – Choose another PCP within that plan;

  – Change to a different managed care plan; or

  – Enroll in the Teachers' Choice Health Plan.

- **Open Access Plans (OAPs)**

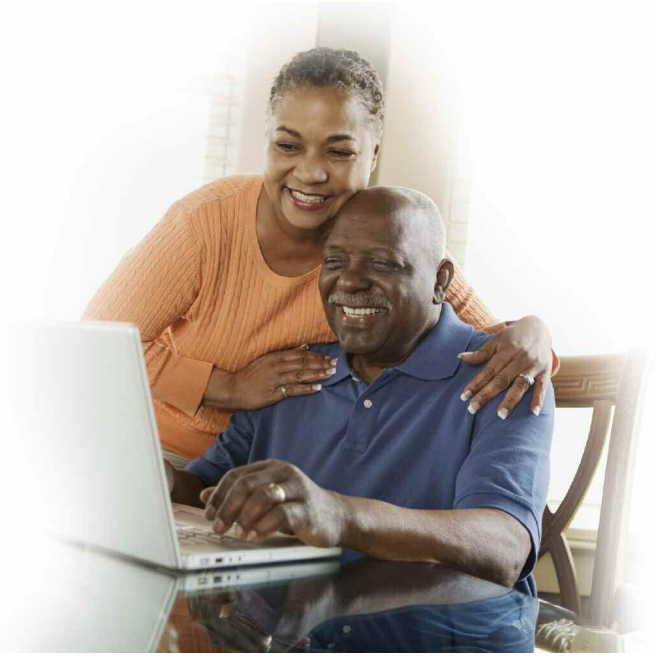
  Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. These plans provide three benefit levels broken into tier groups. Tiers I and II offer two managed care networks which provide enhanced benefits and require copayments and/or coinsurance. Tier III (out-of-network) offers benefit recipients flexibility in selecting healthcare providers, but requires higher out-of-pocket costs. A deductible applies to medical services obtained through Tier II and Tier III providers.

  It is important to remember that the tier level at which benefits are provided is determined by the healthcare provider selected. Benefit recipients enrolled in an OAP can mix and match providers. Specific benefit levels provided under each tier are described on the charts on pages 8-13.

Behavioral Health Services

Teachers' Choice Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under Teachers' Choice Health Plan (TCHP). Behavioral health services are included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services are not subject to separate copayments, limits or other specific provisions. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the TCHP benefit schedule on pages 8-13 for in-network and out-of-network providers. Please contact Magellan for specific benefit information.



Managed Care Plans

Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 8-13. Please contact the managed care plan for specific benefit information.

Disease Management Programs and Wellness Offerings

Disease Management Programs

Disease Management Programs are utilized by the Teachers' Choice Health Plan (TCHP) plan administrator and the managed care health plans as a way to improve the health of plan participants. You may be contacted by your health plan to participate in these programs.

Wellness Offerings

Wellness options and preventive measures are offered and encouraged by the TCHP plan administrator and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside cover of this book and on the Benefits website.

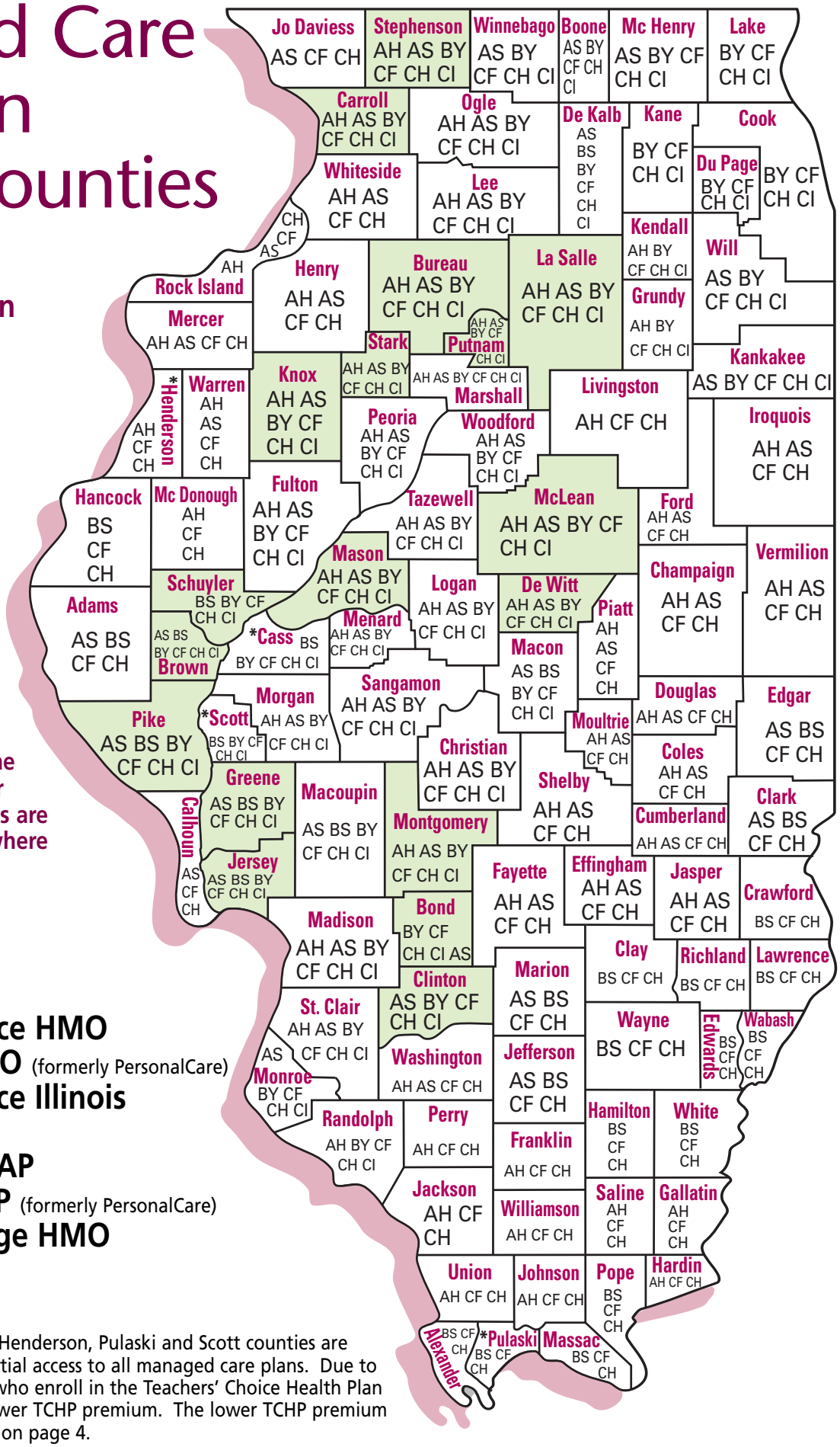
To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Managed Care Plans in Illinois Counties

TRIP Managed Care Health Plans For Plan Year 2013

Shaded areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.



HMO & OAP Carrier Codes:

AH = Health Alliance HMO
AS = Coventry HMO (formerly PersonalCare)
BS = Health Alliance Illinois
BY = HMO Illinois
CF = HealthLink OAP
CH = Coventry OAP (formerly PersonalCare)
CI = BlueAdvantage HMO

Note: TCHP available Statewide

* Members who reside in Cass, Henderson, Pulaski and Scott counties are considered as having only partial access to all managed care plans. Due to this limited access, members who enroll in the Teachers' Choice Health Plan (TCHP) will be charged the lower TCHP premium. The lower TCHP premium is indicated on the rate sheet on page 4.

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	TCHP		HMO
	In-Network	Out-of-Network	In-Network
Covered Services			
Health Plan Year Deductible Per enrollee Note: The annual health plan deductible must be met before plan benefits apply	$500		Not applicable
Out-of-Pocket Maximum* Individual Family	$1,200 $2,750	$4,400 $8,800	$3,000 $6,000
Physicians' Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Physician or Specialist Office Visits • Treatment of illness or injury • Behavioral health	80% after the annual plan deductible	60% of U&C after the annual plan deductible	100% after $20 copayment per visit
Physician or Specialist Office Visits • Wellness care/Preventive healthcare (including womens' healthcare) are not subject to the health plan year deductible	100%	60% of U&C after the annual plan deductible	100%
Outpatient Surgery • When billed as an office visit	80% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $20 copayment per visit
Allergy Tests, Injections and Serum	80% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $20 copayment per visit
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Inpatient services	80% after annual plan deductible and a $200 hospital admission deductible per admission	60% of U&C after the annual plan deductible and a $400 hospital admission deductible per admission	100% after $250 copayment per admission
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization Note: Contact plan administrator regarding prior authorization	80% after the annual plan deductible and a $200 hospital admission deductible per admission	60% of U&C after the annual plan deductible and a $400 hospital admission deductible per admission	100% after $250 copayment per admission

* For an explanation of out-of-pocket maximums see pages 12 and 13.
Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	**Tier II – 80% Benefit**	**Tier III – 60% Benefit**
Covered Services			
Health Plan Year Deductible Per enrollee Note: The annual health plan deductible must be met before plan benefits apply	Not applicable	$300	$400
Out-of-Pocket Maximum* Individual Family	Not applicable	$700 $1,400	$1,700 $3,600
Physicians' Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Physician or Specialist Office Visits • Treatment of illness or injury • Behavioral health	100% after $20 copayment per visit	80% of network charges after the annual plan deductible	60% of U&C after the annual plan deductible
Physician or Specialist Office Visits • Wellness care/Preventive healthcare (including womens' healthcare) are not subject to the health plan year deductible	100%	100%	Covered under Tier I and Tier II only
Outpatient Surgery • When billed as an office visit	100% after $20 copayment per visit	80% of network charges after the annual plan deductible	60% of U&C after the annual plan deductible
Allergy Tests, Injections and Serum	100% after $20 copayment per visit	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Inpatient services	100% after $250 copayment per admission	80% of network charges after the annual plan deductible and a $300 copayment per admission	60% of U&C after the annual plan deductible and a $400 copayment per admission
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization Note: Contact plan administrator regarding prior authorization	100% after $250 copayment per admission	80% of network charges after the annual plan deductible and a $300 copayment per admission	60% of U&C after the annual plan deductible and a $400 copayment per admission

* For an explanation of out-of-pocket maximums see pages 12 and 13.
Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	TCHP		HMO
	In-Network	Out-of-Network	In-Network
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	80% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $150 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	80% after annual plan deductible and $400 emergency room deductible per visit	80% of U&C after the annual plan deductible and $400 emergency room deductible per visit	100% after $200 copayment per visit
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
• Imaging • Diagnostic Tests	80% after annual plan deductible	60% of U&C after the annual plan deductible	100%
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Ambulance Service for Emergency Care	80% after annual plan deductible	80% of U&C after the annual plan deductible	100%
Home Health Care Services Note: Prior approval required	80% after annual plan deductible*	60% of U&C after the annual plan deductible*	100% after $15 copayment per visit
Skilled Nursing Facility Services Note: Prior approval required	80% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Hospice Care Note: Prior approval required	80% after annual plan deductible*	60% of U&C after the annual plan deductible*	100%
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	80% after annual plan deductible	60% of U&C after the annual plan deductible	80% of U&C
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	80% after annual plan deductible	60% of U&C after the annual plan deductible	100% after $20 copayment per visit
Chiropractic Services Note: Chiropractic care for maintenance is not covered	80% after annual plan deductible, maximum 30 visits per plan year	60% of U&C after the annual plan deductible, maximum 30 visits per plan year	100% after $20 copayment per visit

Note: See page 13 for an explanation of usual and customary (U&C) charges.
* See page 6 of the TCHP Summary Document on the Benefits website for benefit limitations.

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	**Tier II – 80% Benefit**	**Tier III – 60% Benefit**
Hospital/Facility Services	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Outpatient/Facility Surgery • When billed as outpatient surgery at a facility	100% after $150 copayment	80% of network charges after the annual plan deductible and a $150 copayment	60% of U&C after the annual plan deductible and a $150 copayment
Emergency Care – Hospital • Facility charges for treatment of emergency medical condition or injury Note: Professional fees may be billed separately	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
• Imaging • Diagnostic Tests	100%	80% of network charges after the annual plan deductible	60% of U&C after the annual plan deductible
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Ambulance Service for Emergency Care	100%	100%	100%
Home Health Care Services Note: Prior approval required	100% after $15 copayment per visit	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Skilled Nursing Facility Services Note: Prior approval required	100%	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Hospice Care Note: Prior approval required	100%	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Durable Medical Equipment (DME) – Rental or purchase Note: Prior approval required for certain DME	80% of network charges	80% of network charges after the annual plan deductible	60% of U&C after the annual plan deductible
Outpatient Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy	100% after $20 copayment per visit	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Chiropractic Services Note: Chiropractic care for maintenance is not covered	100% after $20 copayment per visit, maximum 25 visits per plan year	80% of network charges after the annual plan deductible, maximum 25 visits per plan year	Covered under Tier I and Tier II only

Note: See page 13 for an explanation of usual and customary (U&C) charges.

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	TCHP		HMO
	In-Network	Out-of-Network	In-Network
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Transplant Services Note: Prior approval required	80% after the annual plan deductible and a $200 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator.	Covered in-network only	100%
Pharmacy	**TCHP has a $1,500 prescription out-of-pocket maximum***		
Copayments (30-day supply)	**Minimum**	**Maximum**	
Generic	Greater of 20% or $7	Lesser of 20% or $50	$10
Preferred Brand	Greater of 20% or $14	Lesser of 20% or $100	$20
Nonpreferred Brand	Greater of 20% or $28	Lesser of 20% or $150	$40
	TCHP applies 20% coinsurance to the retail cost of the drug not to exceed the maximum copayment or be less than the minimum copayment		

* See page 16 for details.

Medical Out-of-Pocket Maximum

After the medical out-of-pocket maximum has been satisfied, the plan will pay 100% of covered medical expenses for the remainder of the plan year. It is important to note that certain charges are always the benefit recipient's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges ineligible for payment by the plan include amounts over U&C, charges for noncovered services, prescription copayments, charges for services deemed to be not medically necessary and penalties for failing to precertify/provide notification. For TCHP, $50 of the Medicare A deductible is also the member's responsibility.

The types of charges that are applied toward the medical out-of-pocket maximum for each type of plan varies and are outlined below:

- **Teachers' Choice Health Plan:** The types of charges that apply toward the medical out-of-pocket maximum for TCHP include the annual plan deductible, additional deductibles and coinsurance.
- **HMO Plans:** HMO plans apply copayments toward the out-of-pocket maximum.
- **OAP Plans:** OAP plans do not have an out-of-pocket maximum for Tier I; however, for Tiers II and III, only coinsurance is applied toward the out-of-pocket maximum. Also for Tiers II and III, the out-of-pocket maximum amount must be met for each tier and are cumulative between tiers. For example, once the 'individual' out-of-pocket maximum for Tier II has been met (i.e., $700), coinsurance for Tier II providers is no longer required. However, if the same plan participant then goes to a Tier III provider (out-of-network), they will need to satisfy an additional $1,000 to meet the out-of-pocket maximum for Tier III charges (i.e., $1,700).

Benefits Comparison: TCHP – HMO – OAP Plans

In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator.

	OAP		
	Tier I – 100% Benefit	Tier II – 80% Benefit	Tier III – 60% Benefit
Other Coverage	**The Plan Pays**	**The Plan Pays**	**The Plan Pays**
Transplant Services Note: Prior approval required	100%	80% of network charges after the annual plan deductible	Covered under Tier I and Tier II only
Pharmacy			
Copayments (30-day supply)			
Generic	$10		
Preferred Brand	$20		
Nonpreferred Brand	$40		

Medical Out-of-Pocket Maximums Chart

		CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM			
PLAN	**Out-of-Pocket Maximum Limits**	**Annual Plan Year Deductible**	**Additional Deductibles/ Copayments**	**Coinsurance**	**Amounts over U&C*** (TCHP out-of-network providers and OAP Tier III providers)
TCHP	**In-Network** Individual $1,200 Family $2,750 **Out-of-Network** Individual $4,400 Family $8,800	X	X	X	Amounts over U&C are the benefit recipient's responsibility and do not go toward the out of-pocket maximum.
HMO	Individual $3,000 Family $6,000		X		
OAP Tier II	Individual $700 Family $1,400			X	
OAP Tier III	Individual $1,700 Family $3,600			X	

* Usual and customary (U&C) is applied to charges accrued when utilizing an out-of-network provider. For example, if an out-of-network provider charges $1,000 for a procedure, but the U&C cost for the procedure is $800, the percentage of coinsurance that the plan will pay is based on the $800. The $200 difference between the charges for the procedure and the U&C cost ($1,000-$800) is always the benefit recipient's responsibility.

Plan Participants Eligible for Medicare (Benefit Recipients and Dependents)

What is Medicare?

Medicare is a federal health insurance program for the following:

- Participants age 65 or older
- Participants under age 65 with certain disabilities
- Participants of any age with End-Stage Renal Disease (ESRD)

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is a premium-free program for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution.
- **Medicare Part C*** (also known as Medicare Advantage): Part C is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll into a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Medicare Part D*** (Prescription Drug Insurance): Medicare Part D coverage requires a monthly premium, unless the participant qualifies for extra-help assistance.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

To ensure that healthcare benefits are coordinated appropriately and the correct premium is charged, plan participants must notify TRS when they become eligible for Medicare and send TRS a copy of their Medicare identification card. Plan participants should contact the State of Illinois Medicare COB Unit for any questions via phone at (800) 442-1300 or (217) 782-7007.

* The Teachers' Retirement Insurance Program (TRIP) **does not require** plan participants to choose a Medicare Part C Plan (over the original Medicare Part A and B option) or to enroll in a Medicare Part D prescription drug plan.

Plan Participants Eligible for Medicare (cont.)

Teachers' Retirement Insurance Program Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, **TRIP requires** that the plan participant accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to TRS. Plan participants who are ineligible for premium-free Medicare Part A, as determined by the SSA, are not required to enroll in Medicare.

Retirees, Survivors and Disabled Participants without Current Employment Status (and their applicable Dependents)

Plan participants (including dependents) who are retired, a survivor or a disability recipient without Current Employment Status (such as no longer working due to a disability) who are eligible for premium-free Medicare Part A must enroll in Medicare Part A, but may decline enrollment in Medicare Part B. However, even though TRIP does not require plan participants to enroll in Medicare Part B, **participants who receive the lower Medicare primary TRIP premium (due to having both Medicare Parts A and B) are required to maintain their enrollment in Medicare A and B.** Participants receiving the Medicare primary premium will be subject to the higher non-Medicare primary premium if disenrollment from Medicare Part B occurs. Furthermore, the participant will be charged the higher premium rate retroactively to the date Medicare Part B was terminated. **Plan participants who terminate Medicare Part B coverage must notify TRS immediately and provide the date the coverage termed.**

For the TRIP premium rates, please refer to the monthly premium chart on page 4.

Plan Participants Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD)

Plan participants at any age who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding the Medicare requirements and to ensure the proper calculation of the 30-month Coordination of Benefit Period.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his/her Medicare card to the Teachers' Retirement System (TRS). You may contact TRS at (800) 877-7896.

Prescription Benefit

Plan participants enrolled in any TRIP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level has a different copayment amount. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for coordination of benefits (COB) information.

Coverage for specific prescription drugs may vary depending upon the health plan. It is important to note that formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan they are considering. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

The maximum fill that TCHP plan participants can obtain at one fill at a retail pharmacy is 60 days worth of medication; however, plan participants can obtain a 90-day supply of maintenance medication through the Mail Order Program. A 90-day supply through the TCHP Mail Order Program will cost two copayments instead of three. See pages 12 and 13 for copayment amounts.

TCHP Annual Prescription Out-of-Pocket Maximum

The Teachers' Choice Health Plan (TCHP) has an annual prescription drug out-of-pocket maximum of $1,500 per plan participant. Once this out-of-pocket maximum has been met, prescriptions obtained for the remainder of the plan year will be covered at 100%.

Amounts paid for coinsurance and copayments of prescriptions apply toward the prescription out-of-pocket maximum. Prescriptions obtained at an out-of-network pharmacy do not count toward the prescription annual out-of-pocket maximum, nor does the cost difference that a plan participant is charged when they obtain a brand drug (for any reason) when a generic is available.

Medco: (800) 899-2587
Website: www.medco.com

Plan Administrators

Who to contact for information

Plan Component	Contact For	Administrator's Name and Address	Customer Service Contact Information
Teachers' Choice Health Plan (TCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	**Cigna** Group Number 2457482 **Cigna HealthCare** P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $1,000 applies	**Intracorp, Inc.**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator TCHP (1402TD3) Coventry OAP (1402TCH) HealthLink OAP (1402TCF) Health Alliance Illinois (1402TBS)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Medco** Group Number: 1402TD3, 1402TCH, 1402TCF, 1402TBS **Paper Claims:** Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
TCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for behavioral health services	**Magellan Behavioral Health** Group Number 2457482 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

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